

**STATEMENT OF BILLING/CREDIT/NOTICE OF INFORMATION POLICIES**  
**FOR THE BENEFIT OF OUR PATIENTS (Rev: 10/31/08)**

**1. MEDICARE:**  
 We accept assignment for our Medicare patients and will bill Medicare for you. Do not submit a claim yourself.

Medicare pays 80% of their allowable fee after you have satisfied your yearly deductible. If you have supplemental insurance we are **required** to provide Medicare with this information. In most cases Medicare will forward your claim directly to your supplemental insurance for you.

**Medicare does not pay for routine foot/nail care or orthotics.** They also can limit the number of visits per diagnosis. It is your responsibility to pay for services not covered by Medicare. You are required by Medicare to sign a waiver, when appropriate, indicating that you have been informed that Medicare may not cover certain services and that you accept the financial responsibility yourself.

**2. FOR OUR CONTRACTED INSURANCE PLANS:**  
 We accept payment based on insurance company's allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement.

**It is the patient's responsibility to obtain any necessary referrals.** If no referral is received by your appointment date, we will request you either reschedule or pay for your visit.

2nd insurance billed only if you supply us with the necessary information and will be billed only one time.

**3. NON-CONTRACTED and/or OUT-OF-NETWORK PLANS:**  
 We will do the billing from this office for your Primary Insurance as a courtesy. Please furnish us with a current insurance card. For insurances where payment **MUST** be made directly to you, we request payment at the time of service. Arrangements may be made for monthly payments of larger balances once your payment history has been established.

We request payment at the time of service for any co-insurance/co-pays and deductible.

Please understand, private insurance reimbursement is based on the contract between YOU and your carrier, so payment for our services is YOUR responsibility. We do not accept the responsibility for collecting an insurance claim or negotiating a disputed claim, however, we will assist you in this effort as a courtesy.

2<sup>nd</sup> insurances billed as a courtesy and only upon request.

**4. NO INSURANCE / AUTO / OTHER INJURY CLAIMS:**  
Payment in full is expected at the time of service. In some instances other payment arrangements, such as subrogation (3<sup>rd</sup> party), may be allowed; however, such arrangements must be made with our office prior to your first visit. A letter from your medical insurance carrier to accept subrogation would be required. In most circumstances, we do not accept 3<sup>rd</sup> party claims.

**5. INSURANCE "SET" CO-PAYMENTS:**

Co-payments are due at time of service and it is your responsibility to know the amount and when they are due.

There will be a \$10.00 billing charge for "set" co-payments not paid at time of service, and this alternative will be allowed only one (1) time. Additional requests may result in us asking you to reschedule your appointment.

**6. METHODS OF PAYMENT / MONTHLY STATEMENTS:**  
 We accept cash, personal checks, money orders and Mastercard/Visa. For any balances, we expect payment in full, upon receipt of statement. If full payment is not made, applicable service charges will apply.

For larger balances, we may consider reasonable monthly payments, with services charges applicable. However, this plan **must be** agreed to prior to treatment being rendered.

Monthly statements will include rebilling charges beginning with the second statement at a cost of \$10.00 for each statement beyond the first.

**7. FAILED AND CANCELLED APPOINTMENTS:**  
 Patients who fail to show or cancel their appointments without giving our office 24 hours notice will be charged \$25.00 for the first time and \$50.00 for each time thereafter.

**8. INSURANCE / DISABILITY / MISC FORMS:**  
 There will be a minimum \$10.00 fee for each form requiring physician completion if not requested or paid by your medical insurance carrier.

**9. There will be a charge of \$25.00 for all checks returned due to insufficient funds, and a \$5.00 charge for a declined credit card.**

10. Should my account, or an account for which I am financially responsible, be referred to a collection agency for non-payment, I am aware that I will be responsible for all charges transferred by Ankle & Foot Clinic to the collection agency, including unpaid balances, re-billing fees & any write off fees to cover administrative costs. I also agree to be financially responsible for reasonable attorney fees. Non-payment may result in my being reported to a credit bureau.

11. Per HIPAA guidelines, you are not required to provide us with your social security # unless this is used as identification by your medical insurance carrier. If your social security # is used for that purpose, failing to provide it to us will entail you paying for all visits at time of service. We will ask for a copy of your drivers license to protect you and our clinic from identity fraud.

**\*Please refer to our Notice of Privacy Practice for all details regarding the use and disclosure of your private health information \***  
 I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. This information provided by me is current, accurate and complete to the best of my knowledge.

I authorize all payments to be made directly to Ankle & Foot Clinic of Everett or my provider on my behalf for any services or supplies furnished by my doctor or Ankle & Foot Clinic of Everett and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine benefits or the benefits payable for related services, now or in the future.

Signature \_\_\_\_\_ Driver's License # \_\_\_\_\_  
 Name (please print) \_\_\_\_\_ Date \_\_\_\_\_